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ABSTRACT

Personality and a social support system are two factors that may influence women medical students' choice of a rural primary care specialty. The 2-year study of 11 University of New Mexico School of Medicine women students engaged in 4-month rural primary care preceptorships included interviews and a personality inventory. Three women had generally positive rural preceptorships. They felt accepted by the community and by their preceptors. These women accepted themselves easily as competent physicians and were "judging" types, making fast decisions depending on routine and organization. Five women had mixed experiences. They felt somewhat abandoned by what they considered an unsupportive medical school and they were less integrated into the community. Several of the women commuted home on the weekends, removing themselves even more from the rural community social structure. School-family conflicts caused some to withdraw. Three women had negative experiences. Alone in extremely conservative communities, their isolation was severe. They had no community contact and little preceptor contact outside of work. All three felt inadequate and depressed and their self-esteem suffered. Researchers concluded that women in rural health care need contact with the formal health care system and with appropriate role models. (SB)

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Women Students in Rural Communities: A Preliminary Report

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Women Students in Rural Communities: A Preliminary Report

Introduction

Few women practice health care in rural communities, in spite of the fact that more women than ever are entering medicine.[1] Although research has examined the impact which entering a predominately male-oriented career has had on women,[2] there has been very little interest in why so few women enter rural health care. Geographic maldistribution of physicians has increased despite the concurrent increase in the total number of practicing physicians. One factor which compounds this maldistribution is medical education itself which often exists in large urban centers where the emphasis is on technological subspecialty care.[3]

As the awareness of the growing health care problem increases, so has the research investigating physicians' preference in geographical choice. Some studies have found rural background of the physician or the physicians' spouse to be important indicators of choice of rural health care.[4,5,6] Other studies point to the importance of improving community services in order to make rural life more attractive to the incoming physicians.[7] And several other studies have shown some predictive relationship between personality type and geographical choice.[8,9]

The little research which has been done in the area of women physicians in rural primary care found that the majority of women practicing in rural communities were predominately married and tended to be from foreign medical schools.[10,11]

It would appear that the decision to enter rural health care is based on a complex of factors, including demographic choice, predisposing personality variables, the influence of medical education in a tertiary care

setting, and the community itself. Whether the same dynamics hold for women remains to be investigated and is the purpose of the ongoing research which is partially presented here.

At the University of New Mexico School of Medicine a new program, the Primary Care Curriculum (PCC), has been operating since 1979 with an emphasis on educating more physicians to practice in rural communities. As part of the curriculum, within the first year, all students practice for four months in a rural primary care setting. Students move to the community and work with a clinician or a number of clinicians. Under close supervision, the students see patients for which there is some primary responsibility, attend appropriate clinical functions, as well as become involved in the community through specific research projects of the students own design.

All students are admitted into the School of Medicine, and students are selected into the Primary Care Curriculum based on interest in rural primary care. Those not interested or not selected into PCC enter the conventional curriculum. A consistently greater proportion of the classes in PCC are women compared to the conventional curriculum (40% versus 28%). The presence of a substantial number of women in the Primary Care Curriculum provide an opportunity to research the experience which women have in rural settings early in their training, in order to help assess which factors might influence women to choose rural primary care. An ongoing longitudinal study in medical education has been in operation since 1979. Aspects of the study are presented here.

Methods

This research covered a two-year span of time and involved eleven women medical students during their four-month, rural, primary care preceptorship. Information was gathered from interviews with students before, during,

and after their rural preceptorship. Information was also gathered from the staff, faculty, and circuit riders (faculty who visit students in their rural sites) who were involved in the supervision of the individual students during their clinical rotation. Myers Briggs Personality Inventories (MBPTI) were also administered to all students at the beginning of school and shortly after returning from their rural experience. The Myers Briggs is a psychometric test instrument which characterizes individuals into one of sixteen personality types, based on their cognitive styles. These types are determined by four dichotomous scales. The Extroversion-Introversion scale measures whether a person chooses to direct their mental activities outwardly or whether they are more inner-directed. The Judgement-Perceptive scale measures the capacity to make decisions quickly and to follow through on these decisions as opposed to the flexibility of waiting until all information is in before making a decision. The Sensing-Intuitive scale is based on whether a person prefers to perceive the world in a factual, realistic way or whether they perceive possibilities through ideas and imagination. The Thinking-Feeling scale describes whether a person comes to make decisions based on logical, analytical process or whether they weigh values influenced by interpersonal relationships.[12]

Sample. Eleven women from the first two classes of the Primary Care Curriculum were interviewed during the years 1981 and 1982. As a group, the students had an average age of 21 years old. Eight of the women were Anglo, two were Hispanic, and one was Native American. Five women were from urban communities and six were from rural communities. Three women were married upon entering medical school; two were married during their first year; and one was divorced at the end of her rural experience. Three of the women had children.

Results

The women fell into three categories which lay along a continuum of enjoyment in their rural preceptorship. One group of students (3) had a positive experience in the rural setting; one group (5) had some positive experience, however, felt the rural experience to be negative for particular reasons; and a third group (3) felt their experience to be totally or almost totally negative.

Rural Experience: Positive Experiences

Three women appeared to have an overwhelmingly positive experience during their rural preceptorship. Two of the women were at the same clinic during different years. The clinic where they worked was a fairly large one, and although the community was conservative and difficult to integrate into, the clinic itself offered a substantial network with whom the students could relate and feel comfortable.

> The clinic seems to be like a very large family. Everybody knows one another and everybody is very close to one another. The community itself is not something that I've ever been comfortable in but the clinic seems to be my community.

> It (the clinic) was great. Everyone was so supportive. They treated me like a doctor and a woman and gave me a lot of responsibility. At first it was a bit overwhelming but then when I realized I could do it, it was exciting. I really liked the people there; we became good friends.

Although the third student had no clinic, the community itself offered a fairly unique experience. Although rural and isolated, the town had a substantial middle to upper middle class Anglo population who shared similar interests as the student. She was able to participate in various activities which were not always available for other women students.

Two of the women got along very well with their male preceptors. They

felt them to be very supportive as well as encouraging them to develop their interests in women's health issues. As a result, the students did a lot with women patients, and the patients were very comfortable with them. One of the women students was actually critical of her male preceptor, as well as some other male physicians in the clinic, particularly in terms of how they related to women patients.

> They're pretty rough. They don't really understand women. I felt like I could probably give as good an exam as they by the time my experience was over. In fact many of the women patients asked for me. It really increased my interest in OB/GYN.

Tensions occurred with one of the women between her and her preceotor; however, she could not entirely label the origin of the tension. She felt that perhaps he did not fully understand what a first year student could do. She also wondered if there were particular difficulties because she was a woman.

> I think he may have been uncomfortable with me because I was a woman. There were times when all I got were women patients and I couldn't see any of the men. But we managed very well.

All three women felt as though they gained a great deal from their clinical experiences, had a good exposure to a number and variety of cases, and felt like they had a good grounding in rural primary care. Two of them seemed to be very interested in continuing in rural primary care as their future goals in medicine.

Mixed Reactions

Five women reported having mixed reactions to their rural clinical clerkships. Three of the women primarily saw their problem to lie with the School of Medicine which they felt did little to give them the type of support they had expected. For instance, one student, a minority student, was

placed in southeastern New Mexico, a very conservative area of the state. She often felt peripheral to the community and had little contact with her clinical preceptor. In fact, her contact was so minimal that she found herself seeing almost no patients. She decided, with her circuit rider, that she needed to contact a new preceptor; however, it was also decided that she would make that initial contact rather than the school. She perceived this decision as a statement of the lack of support from the school which left her feeling more isolated, both in the community and from the school itself.

> In ways I felt somewhat left, all of a sudden I was on my own. It seemed as though it should have been the school's responsibility. Here I'm the one having to find a preceptor. I can understand why they are putting me in that position but it just makes me feel so far away and so isolated, so far removed from them.

Administratively, the rural clerkship was run by another office, although remaining under the domain of the PCC curriculum. Often students felt confused by the difference in the approach from the preceptorship office and frustrated because they were not responding to the students as the students were accustomed. Two students in particular felt that they received little support coming from the school during a time they considered that personal attention was needed. The preceptorship office, on the other hand, felt that the two students should deal with the situation which had arisen on their own. This resulted in the students feeling isolated from the school, and with few resources readily available in their new community, set "adrift". Although this did not seem to affect their relationship with the clinic in which they were practicing as such, it did seem to have an effect on how the students felt about themselves during the summertime.

> I was so worried and I just couldn't have anyone to turn to. If the school wouldn't respond to our concerns, who would?

Two women left their families in Albuquerque and traveled to rural preceptorship sites, alone. They also had mixed responses about their clinical experiences; however, this seemed related to the bind that they felt they were in between school and family. One woman, who had a very supportive relationship with her husband around the issue of a rural preceptorship, alone seemed to withdraw, perform poorly in the clinic, and gave the impression that she was depressed. It was the first time she had been away from her family and felt few supports readily available from the community she entered.

> I've always been active in welcoming new people into our community for the church. This is the first time I felt really like no one is welcoming me.

The women found themselves living in "weekend relationships" which was hard for them and their families. They felt they had had just enough time to "catch up" with the week's events of their families lives before they had to leave again. Although spouses for the most part were supprotive, the women felt peripheral to their families. This feeling seemed to transfer to their relationship to the rural community itself. They participated often very little, eventhough their clinical experience seemed very interesting. One woman in particular worked a great deal of the time she was away from home.

> I was really burned out by the end of the summer. It was hard coming home on the weekends and then leaving again. I felt as if I lost contact with my family and although I put a lot of energies into work, by the end of the summer I was really very tired of that.

Negative Reactions

A major problem was the single women who ventured into conservative communities alone. Two women were Anglo who entered very conservative Hispanic communities in northern New Mexico, and one woman was a minority student who

entered a very conservative Anglo community in southern New Mexico. These communities had a comparatively large minority population; however, the discrimination between the Anglo and the minority populations was also fairly well known. All three women had difficulty adjusting to the isolation which they immediately felt. Not only did they feel entirely peripheral to the community, they also had little contact with their preceptor and the preceptor's family outside of work. This was partially because the preceptors themselves had very full social lives and had very little time to include the students directly, unless the students wanted to join in with the ongoing community activities of the preceptor and his family. For two women it was also because the spouses were uncomfortable with them. The women seemed to find few women available for either friends or for role models.

> I feel really isolated here; I can't ever run. I finally found someone to play tennis with but my fear is that if I ran I might be in trouble. It's very hard being a woman in this community.

It is interesting that all three women had more than one preceptor, always at their own initiation. Partly there was a need for more ongoing contact with more than one person. However, it also seemed to be a search for someone who would be willing to respond to them in ways that they were needing.

> He's just too busy; he doesn't have much time for me. He will give me patients, sure, and he's very good if I catch him, but I hate to interrupt him when he is just in transit from one patient to another.

> He just doesn't even have time to see me in his office, and I can go on rounds with him and watch him deal with patients, but I don't feel as though he has any time to help me with my growth and development.

> He's so busy, in some ways he's very great; even when he's that busy he's taken some time out for me. But still, I am always feeling a little bit hesitant to interfere with his schedule by asking him for more ffedback. But the feedback he gives me is very encouraging.

Unfortunately, all the women took this as a sign of some personal failing of theirs. All three women personalized the lack of attention and felt that they were inadequate in some way. Part of the feeling of inadequacy lay in the students' perceptions that fellow students were enjoying their rural experiences far more than they were enjoying theirs. And as a result, they often felt they were missing something that was there, they were unable to do something that other students could do, and they were falling short of standards set for them.

> I don't know, I just really felt like I failed. Nobody else had the same experience as I did. I felt as though all the other students had a good experience, were able to develop friends in their communities, and I couldn't do that. I felt really isolated, and I felt like I was the only student who was having that problem.

All three of the students became, in their own descriptions of themselves, somewhat depressed, reflecting their own feelings of low self-esteem and withdrawl. Unlike the married women, who seemed to withdraw out of a difficulty of the bind of trying to meet the needs of their family and preceptors, these women withdrew and became depressed out of their own feelings of failure and their own sense of loss about their expectations about what they could do.

> I don't think I could ever go into a rural community and live. I feel like a real failure for saying that, but that was just such an isolating experience for me, and the people were so difficult. I never felt that whenever I've been in other situations, but maybe I'm someone who should stay in a large metropolitan area.

These students were also students who particularly felt at a disadvantage for being women. One of them had difficulty with the preceptor whom she felt expected her to give more to her clinical experiences than what she was willing to do. Another felt some difficulty with the preceptor's wife who could not deal with her in any capacity, and, as a result, had little or no contact with her socially. The third women felt physically constrained by being a single woman in a very conservative town.

Myers Briggs Results

The first administration of the Myers Briggs Personality Inventory found that the majority of women were extroverted, intuitive, feeling, with a slightly more perceptive orientation (Table I). By the second administration, the one area where there was a significant shift was in the judging area, where women indicated a judging preference more frequently than before. When the three women who enjoyed their experience were controlled, the shift from perceptive to judging among the other women was even more dramatic (see Table II).

Discussion

It appears that personality factors may have an impact on how women perform in isolated, rural communities. Women who enjoyed their clerkships were more frequently the judging types, and women switched to favor this function by the time they had finished the clerkship. The judging function is one where decisions are made quickly, with routine and organization crucial to a person's mode of functioning. Judging types tend to be seen as responsible, reliable, and consistent in their manner of performance. One might speculate that this is important for women performing in the role of peripheral members in a rural community. Not only were they called upon to make clinical decisions and to assume clinical responsibilities,

they were also carrying the expectations from themselves and the school to act in ways far beyond what they were comfortable. One might speculate that those women who were more perceptive and valued flexibility were not as comfortable in situations which called for them to be organized, and "responsible". A rural community may either demand a certain type of physician, or students may perceive such demands through their own self-expectations.

This data also suggests that support systems are important in the life of a rural woman physician. Women students who were able to enjoy their experience and benefit from the small communities were those who were able to develop a sense of acceptance rather than isolation from the communities and clinics. They were women who were either with fellow students from the school or were able to utilize the already existing support systems within that community. Those students who were accepted also accepted themselves more easily as competent physicians, with the additional ability to perform medicine within a small isolated community.

Women who did not enjoy their rural experiences were women who were disappointed with the support gotten from the school and the community and were also disappointed in themselves. They remained peripheral to the community and disliked that area of the state.

One might speculate that women in medical school, although in a male-dominated profession, tend to be accustomed to academic situations where the expectations are highly predictable, and therefore, indirectly supportive. Yet, when situated in an isolated environment, with little access to expectable norms and few supports available to help them both as professionally growing women, as well as individuals, women lose their sense of confidence and internalize the seeming failure. There were also few women

role models to whom they could related, often leaving students to struggle alone with developing their role of woman physician.

The paper suggests the importance of helping women develop social support systems in order to continue in rural communities. It appears that for women to become comfortable in a rural setting they have to have more contact with the formal health care system as well as more appropriate role models. Solutions such as women preceptors and pairing students with one another are strongly suggested. It appears that mere exposure to a rural community will not help a woman define her role as a future physician in rural primary care. Instead, a carefully developed plan providing her with both support systems as well as role models is crucial.

Table I

Comparison of Myers Briggs Personality Type
Before and After Rural Clerkships

		Before Clerkship (n=11)	After Clerkship (n=11)
I.			
	Introversion	3	4
	Extroversion	8	7
II.			
	Sensing	2	3
	Intuition	9	8
III.			
	Feeling	7	7
	Thinking	4	4
IV.			
	Judging	6	3
	Perceptive	5	8

Table II

Comparison of Myers Briggs Personality Types
Before and After Clerkship Controlling for those Women Enjoying the Clerkship

		Before Clerkship (n=8)	After Clerkship (n=8)
I.			
	Introversion	3	4
	Extroversion	5	4
II.			
	Sensing	2	3
	Intuitive	6	5
III.			
	Feeling	5	5
	Thinking	3	3
IV.			
	Judging	6	2
	Perceptive	2	6

References

1. American Medical Association, Profile of Medical Practice, 1980
2. Bobula J: Practice characteristics and incomes of male and female physicians. J Med Educ 55, 1980
3. Bloom S: The medical school as a social system: a case study of faculty-student relations. Milbank Memorial Fund Quarterly 49, April, 1971
4. Cooper J, Heald K, Samuels M, et al: Rural or urban practice: factors influencing the location decision of primary care physicians. Inquiry Vol XII, March, 1975
5. Taylor M, Dickman W, Kane R: Medical students' attitudes toward rural practice. J Med Educ 48, October, 1973
6. Parker R, Tuxill T: The attitudes of physicians toward small community practice. J Med Educ 42, 1967
7. Diseker R, Chappell J: Relative importance of variables in determination of practice location: a pilot study. Soc Sci and Med 10, 1976
8. Quenk N: Characteristics of Physician Work Settings in Relation to Myers Briggs Preferences. Paper presented at First National Conference on Myers Briggs Type Indicator, Gainesville, Florida, October, 1975
9. Myers IB: Relevance of Type to Medical Education. Center for Application of Psychological Type, January, 1974
10. D'Elia G, Johnson I: Women physicians in a non-metropolitan area. J Med Educ 55, 1980
11. Moore-West M, Kaufman A, Lucero S, et al: A descriptive study of women physicians in rural practice. J Am Med Women's Assoc (in press)
12. Myers IB: Introduction to Type Center for Application of Psychological Types, 1962